1994/1997–2004/2007: changes in the requests to the help-line of the Institute of Clinical Sexology

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Objective: To describe changes in the requests presented by men and women calling the help-line of the Institute of Clinical Sexology (Rome, Italy).

Design and method: The study included all the valid schedules of the calls received between July 1994 – June 1997 (G1, N=859) and July 2004 – June 2007 (G2, N=944). The counsellors'team was staffed by experts in sexology. The information used for analysis comprised: callers'demographic characteristics, reason for their call, sexual problems reported, previous doctor contacts, items discussed and referrals. Data were analysed using descriptive statistics and univariate analysis (Chi-Square and ANOVA).

Results: An increase of callers was found ($p < .05$), with men calling more frequently than women ($p < .05$). The majority of the reported sexual difficulties were premature ejaculation (41.4%) and erectile dysfunction (41.9%) for men. While, the most frequently sexual difficulties declared by women were vaginismus (27.4%) and coital anorgasmy (27.4%). Moreover, the comparison between G1 and G2 showed an increase of callers with relationship troubles, and of those who called for information on sexuality ($p < .05$); on the other hand, there is a decrease in medical requests ($p < .05$).

Conclusions: Due to its easy accessibility and anonymity, this help-line represents the first (formal and informal) request for help by the people who call and therefore it can be a useful link between health services and callers.

Male-to-Female sex reassignment surgery: our experience

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Introduction: Male-to-female transsexual surgical techniques are well defined and give good cosmetic and functional results.

Material and Methods: All patients had been cross-dressing and living as women. Patients were at least 23 years old. Procedure includes bilateral orchidectomy, amputation of the penis, creation of the neovaginal cavity, lining of this cavity and reconstruction of a urethral meatus and, finally, construction of the labia and clitoris.

Results: Mean follow-up is 32 months (range 4-150). 11 patients showed partial necrosis of the scrotal flap; in 7 patients there was an important postoperative bleeding that was treated surgically in 3 case. In the long term, neomeatus stricture occurred in 6 patients and was treated with meatotomy. 11 patient developed stenosis of the neovagina. Hematoma of the labia majora of the neovagina occurred in 24 case and resolved spontaneously in all caes. Prolapse of the neovagina occurred in 12 patients. 3 patients developed a right leg muscular contusion (due to the prolonged lithotomic position during operation), which required fasciotomy of the peronaeorum communis fascia. 69 patients have been evaluated by a questionnaire after 12 months: physical and functional results of surgery were judged to be excellent and patients were satisfied with the quality of the functional genitalia as well as cosmetic result.

Conclusions: Although the surgical techniques for vaginoplasty have evolved significantly, it must be stressed that both medical and surgical treatment are rarely perfect. Major complications are possible, and revisional surgery is sometimes required to optimize aesthetic results.

Androphase: male sexuality afer 45?

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Today man lives much more over a long time span. It has opportunity that the man who lived in the millenia before never had. Today man has the possibility of living a new phase of his life and manhood, a new neo andro phase. From here the term androphase.

The existence of male changes and modification with age have been or a long time questioned. The importance of sexual changes with aging have grown in modern society. Reasons for that are longer life, better health conditions, increased importance of non reproductive aspects of human sexuality. Male sexual changes with aging end with regression of all aspects of masculinity. Androphase has a different onset and development, different clinical manifestations. Androphase can begin very early (from 40-45). There are three phases of the androphase: beginning phase, florid state and late phase. Late androphase is the most known phase. It is usually confused with andropause as a whole. In late androphase penetration is not possible. The florid state is featured by inconstant erections, intermittent potency and ability to penetrate, high sensibility to stressors. The beginning phase is a phase where modifications are not always realized . In some people, androphase modifies their sexual desire; in others it shakes their male identity. In other people androphase has repercussions on their erection and penetrative capacity, in some it creates ejaculation problems. For most men androphase means difficulties in having sex, the way they would like to have, the way they used to have.

Psychological and Ethical problems with children with Disorders of Sex Development

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The psychological research literature on children born with disorders of sex development (DSDs) has largely focused on their psychosexual development, with less attention given to other aspects of their psychosocial well-being, including the presence of clinical range behaviour problems. Children with DSDs may be at risk for behaviour problems for several reasons: (1) the chronic nature of their medical condition; (2) co-morbid medical problems; (3) the need for repeated in-patient hospitalizations and medical evaluations; (4) stigmatization for pervasive cross-gender behaviour (when this is an aspect at the DSD) and (5) family stress related to caring for a child with a chronic medical condition.

The present paper will examine behaviour problems of children with DSD and discuss the complex ethical and psychological problems with which medical staff and parents involved in the care of these patients have to cop.

Sex and infidelity. Couples therapy interventions for problems with extramarital affairs: a phasic model

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A number of couples request sex therapy because of relational problems resulting from an extramarital affair. In treating such couples, five phases have been identified: (1) the start, (2) suspicion and negation, (3) explosion and impulsive reactions, (4) making choices and deadlock, (5) working through. Clients may enter therapy at very different points in these phases. Some come in full crisis, others in the deadlock phase, not being able to decide what to do. A different therapeutic intervention is proposed for each phase.

The Narrative Model in Sexual Education: Research and Applications

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The Narrative Method is a new approach to use the evolutionist theory and the constructivism approach in Sexology, Psychology and Psychotherapy.

This application to the Sexual Education gives a constructivist support to the classic behaviour and cognitive model, and introduces the concept of pursuit of the meaning to know the sexuality.

The meaning is described with the development in six dimensions: from the reproduction to the procreation, and proposes reference to the Triune brain theory (Mac Lean, 1973).

In this prospective will be shown the first results about two researches with students of primary and secondary school.

The management of erectile dysfunction after surgical therapy for localized prostate cancer

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The number of newly diagnosed cases of prostate cancer continues to rise every new year. These cases (230110 in 2004 in the US), represent 33% of all new male cancer cases diagnosed in that year. 39000 men died of prostate cancer in that same year (10% of all male cancer deaths), and we can now estimate that a men born in the US today has a 1 in 6 (17%) probability of developing prostate cancer in his lifetime.

Localized prostate cancer can now be treated with a wide number of options. 61% of men are treated with surgery; 41% with hormone therapy; 33% with external radiation, 14% with brachytherapy and 7% are in watchful waiting. As disease-free survival rates are quite similar between these treatment modalities, a paradigm shift is now becoming evident in this field, that is to say, clinicians are now investing in reducing the morbidity of these procedures. Sexual function, of course, is in the front line of this subject as an even more critical factor in the choice of treatment for localized prostate cancer. It is important to stress, however, that clinical studies reporting erectile function outcomes after localized prostate cancer treatment often demonstrate poorly interpretable and inconsistent manners of assessment as well as widely disparate rates of erectile dysfunction and function. Even with the more recent techniques of robotic prostatectomy, there exists little evidence based information on return to potency compared with the other previous surgical techniques that we have at our service.

Strategies to promote recovery of erection:

Anatomy / Improved Visualization - Robotic / Surgical Control

"Reconstructive" Measures

Sural nerve grafts

Pharmacology

Penile prosthesis

Neuro-Protection: Imunophilins

The reluctance to choose more effective regimens of treatment due to fear of loss of sexual function has been demonstrated. As the demanding for optimal post-treatment erectile function is increasing its importance, it is quite conceivable that pharmacological prophylaxis with oral or intracavernous drugs will be expanding its role in the future strategies for the achievement of penile rehabilitation.

Lower urinary tract symptoms and erectile dysfunction: a role for PDE-5 inhibitors?

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It is well established that lower urinary tract symptoms (LUTS) and erectile dysfunction (ED) are multifactorial and involve many pathophysiologic mechanisms. Until recently,